METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent they are available.

2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure.

3. Payment for physician, dentist and other individual practitioner services will be equal to the lesser of the billed charge or the State's fee for that service. Fee schedules are posted on the Executive Office of Health and Human Services web site under the Providers and Partners tab: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Hospitals.aspx. All governmental and private service providers are reimbursed according to the same published fee schedule. The Medical Assistance Program rates were set as of July 1, 2017 and are effective for services on or after that date.

4. The following is a description of the payment structure by items of service.

   a. Inpatient hospital services: as described in attachment 4.19A.

   b. Outpatient hospital services: The Medical Assistance Program will pay for outpatient hospital services using a fee schedule approach based on, but necessarily identical to, the Medicare outpatient prospective payment system. Specific provisions are as follows:

      1. In general, payment will be by fee schedule, with the fee multiplied by the number of allowable units on the claim line. The fee schedule is located at the following address: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf Fees will be derived as follows:

         a. For visits, surgeries, imaging procedures, drugs, and other services where Medicare pays hospitals using Ambulatory Payment Classification (APC) groups, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, 2020 outpatient rates will be increased by 7.2%. For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change to the Centers for Medicare and Medicaid Services OPPS fee schedule posted January of the current calendar year.

         b. For physical, occupational, and speech therapy services, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, 2020 outpatient rates will be increased by 7.2% For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change to the Centers for Medicare and Medicaid Services OPPS fee schedule posted January of the current calendar year.

         c. For laboratory services with dates of service on or after January 1, 2016, payment will be at the non-hospital community laboratory rate. The fees are effective for claims with a date of service on or after January 1, 2016. The fee schedule can be found on the EOHHS website at the address listed above.

For observation services, EOHHS will pay an hourly fee from the 8th to the 24th hour of observation. The agency's observation fee was set as of July 1, 2019 and is effective for services provided on or after that date. The observation fee is included in the fee schedule found on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, outpatient rates will be increased by 7.2%. For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change to the Centers for Medicare and Medicaid Services OPPS fee schedule posted January of the current calendar year.

unlisted services and other rare situations were no fee can be calculated, payment will be at a percentage of charges.

2. Payment by fee will be modified in the following situations:
    a. For bilateral services as appropriately designated by the modifier 50, payment will be at 150% of the otherwise applicable amount.
    b. For drugs covered under Section 340B of the Public Health Service Act as appropriately designated by the modifier UD, payment will be at 100% of billed charges.

3. Certain types of services are subject to discount payment when a claim contains more than one line showing procedure codes within each type of service. The line with the highest fee will be paid at 100%, the line with the second-highest fee will be paid at 50% of the otherwise-applicable fee, the line with the third highest fee will be paid at 25% of the otherwise-applicable fee, and the fourth and all subsequent lines will be paid zero. Discounting will only apply within each type of service. For example, if a claim contains three lines for an x-ray, a CT scan, and an ultrasound, each line will be paid 100%. The seven types of service are as follows:
    a. Significant procedures subject to discounting as designated by Medicare with APC Status "T." (In general, Medical Assistance will use the same list of procedures as Medicare, but specific exceptions may be made.)
    b. Computed topography scans
    c. Ultrasound
    d. X-rays
    e. Therapeutic radiology
    f. Nuclear medicine scans
    g. Magnetic Resonance Imaging

4. Some claim lines will be packaged, that is, the line will be considered paid but with a payment of zero. Packaging will apply to lines with anesthesia and recovery room codes (regardless of procedure code), lines without procedure codes, and lines with procedure codes designated as packaged under Medicare. (In general, Medical Assistance will use the same list of packaged procedures as Medicare, but specific exceptions may be made.)

5. Out-of-State hospitals will be reimbursed for outpatient surgery services provided to Rhode Island Medical Assistance Recipients at a rate equal to fifty-three (53%) of the out-of-state hospital's customary charge(s) for such services to Title XIX recipients in that state. The outpatient reimbursement for all other services, exclusive of laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery rate.

6. Payment for all outpatient services will be final, with no year-end settlement process.

7. Hospital outpatient claims and payments are processed through MMIS.

8. Only hospitals and provider based entities, in accordance with 42 CFR 413.65, are reimbursed according to the outpatient hospital reimbursement methodology.

9. Outpatient Supplemental Payment and UPL Calculation

    a. For the outpatient services provided for the period after July 1, 2009 each hospital licensed by the RI Department of Health, except those hospitals whose primary services and bed inventory are psychiatric, is paid an amount determined as follows:

        1) Determine the sum of all Medicaid payments from Rhode Island MMIS to hospitals made for outpatient and emergency department services provided during each hospital's fiscal year ending during 2008, including settlements.

        2) Multiplying the result of (1) above by a percentage consistent with Medicare cost finding principles; and

        3) The Outpatient UPL calculation is an estimate of Medicare outpatient cost for private hospitals. Specifically, a ratio of Medicare outpatient costs to Medicare outpatient charges is applied to Medicaid outpatient and emergency room charges to determine total Medicaid cost (the limit). Total Medicaid outpatient and emergency room payments are then subtracted to determine the UPL gap, which is the basis for the size of the outpatient supplemental payment. The UPL gap is calculated using an aggregate of the individual hospital gaps for state owned and operated, non-state owned and operated, and private hospitals.

The outpatients UPL calculation is a reasonable estimate of the amount Medicare would pay for equivalent Medicaid services.

Cost information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V, Column 5, Line 202.

Charge information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V Columns 2, Line 202.

The UPL is trended for inflation and utilization using CPI-U: Hospital and Related Service – CMS Health Care Indicators, Table 7: Percent Change in Medical Prices, and OP PPS Payment Increase and Market Basket Update

4) Pay each hospital on July 20, October 20, January 20, and April 20 one-quarter of the product created by multiplying the result of (1) above and (2) above.

c. Payment will be made for rural health clinic services at the reasonable cost rate per visit established by the Medicare carrier. Payment for each ambulatory service, other than rural health clinic services, will be made in accordance with the rates or charges established for those services when provided in other settings.

5. Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for nonpayment under Section(s) 4.19-B of this Sate Plan.

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26, Medicaid agency assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The State can reasonable isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (B) of this State plan, the Medicaid agency will utilize modifiers that are self-reported by providers on claims that indicate if an OPPC occurred. When one of the OPPC modifiers is present on the claim, the Medicaid agency will calculate a non-payment amount to ensure that *the* services rendered which the OPPC pertains to are not paid by the Medicaid agency.

This provision applies to all providers contracted with the Medicaid.

In the event that individual cases are identified throughout the PPC implementation period, July 1, 2012 through January 10, 2013, the State will adjust reimbursements according to the methodology above.

FEB 11 2013

– *No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.*

– *Reductions in provider payment may be limited to the extent that the following apply: (z) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.*

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

FEB 11 2013

(2) Early, periodic, screening, diagnosis, and treatment of individuals under 21 years of age: on the basis of a negotiated fee schedule.

(3) Family planning services, drugs and supplies for individuals of child-bearing age when such services are under the supervision of a physician, as determined according to the elements inherent in the family planning service or the drugs and contraceptive devices necessary: on the basis of a negotiated physician fee schedule and the pharmacy fee schedule.

e. Physicians' services: on the basis of a negotiated fee schedule

f. Medical care of any other type of remedial care recognized under State law furnished by licensed practitioners within the scope of their practice as defined by law limited to:

(1) Podiatry services: on the basis of a negotiated fee schedule.

(2) Optometry services: on the basis of a negotiated fee schedule.

g. Home Health Services: In order for EOHHS to calculate the applicable Home Health base rate, each provider must submit a completed General Application for Enhanced Home Health Reimbursement to EOHHS. Base rates, which are defined as the minimum reimbursement rate plus any additional enhancements that the provider qualifies for, are available on the fee schedule, updated as of October 1, 2018, and available at http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims/FeeSchedule.aspx. Effective July 1, 2019, and each July 1 thereafter, the base rates for personal care attendant services and skilled nursing and therapeutic services, provided by home care providers and home nursing care providers, will be increased by the New England Consumer Price Index card as determined by the United States Department of Labor for medical care

Home Health Base Rate methodology: Minimum reimbursement rates will be adjusted based on the following qualifications:

1. Staff Education and Training
   - Enhanced Reimbursement per 15-minutes for all Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency.
   - Qualifications: The qualified agency must offer in-services at a frequency at least 20% over the RI Department of Health's licensure requirement. This means that at least fourteen (14) one-hour in-services will be required in a year.
   - How to Receive Enhancement: A plan of scheduled in-service topics, dates, times and instructors should be submitted to EOHHS for the six month period following initial application for this enhancement. To continue receiving the enhanced base rate beyond the initial six-month period, the agency must submit for each in-service the title, training objectives, number of CNAs on the payroll on the date of the in-service, and a copy of the in-service sign-in sheet. Submissions should be for at least seven (7) in-services over a six-month period.
2. National Accreditation or State Agency Accreditation
   National:
   - Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency.
   - Qualifications: An agency with current National Accreditation is entitled to this enhancement.
     - Community Health Accreditation Program (CHAP) or
     - Council on Accreditation (COA) or
     - Joint Commission for Accreditation of Healthcare Facilities (JCAHO)
   - How to Receive Enhancements: Submit current CHAP, COA or JCAHO Accreditation certificate, and copy of the most recent survey results. Submit new certificate(s) and survey results as they are completed to continue payment of the enhanced base rate.

Note: Agencies can either receive State Accreditation or National Accreditation, not both.

State:

- Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency. The goal of this standard is to encourage home health agencies to development and implement initiatives that result in high valve, client-oriented, effective care and services.
- Qualifications: Available to home health agencies with National Accreditation (CHAP, COA or JCAHO).
- How to Receive Enhancement: Submit application for an on-site review and successfully meet Accreditation Standards. In addition, at the request of the home health agency, DHS will review evidence provided that demonstrates exceeding Department of Health Regulations. Evidence may be demonstrated through policy, procedures, client records, personnel records, meeting minutes, strategic plans, etc. Emphasis will be placed on how the evidence is linked between the different sources i.e. policy/procedure compliance noted in record documentation.

3. Client Satisfaction, Continuity of Care, and Worker Satisfaction
   - Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care and Homemaker Services for each of these three areas (client satisfaction, continuity of care, and worker satisfaction) based on former enhanced standards.
   - Qualifications: Maintain compliance with applicable standards. If found out of compliance during random site visits, providers may lose the enhancement for the area out of compliance or be asked to submit a corrective action plan.

If providers are providing care outside of regular business hours or are providing care to individuals with higher acuity, providers may receive an additional two (2) add-ons, if they bill using modifiers. These add-ons are in addition to the base rates defined above.

1. Shift Differential:
   - Reimbursement: $0.375 per 15-minutes of Personal Care and Personal Care/Homemaker Combination services provided during qualified times.
   - Qualifications: Only services provided between 3:00PM and 7:00AM on weekdays, or services on weekends or State holidays qualify for this enhanced reimbursement.
   - How to Receive Reimbursement: Submit claims in the correct amount (Base Amount plus any other enhancements plus shift differential enhancement) to DXC with modifiers.
2. High acuity patients:
   - Reimbursement: $0.25 per 15-minutes of Personal Care and Combination Personal Care and Homemaker Service provided to a client assessed as being high acuity by the agency Registered Nurse based on sections of the Minimum Data Set (MDS) for Home Care.
   - Qualifications: A client is considered high acuity if they receive a following minimum score by an agency Registered Nurse in one area:
     - "5" on Section B, Items 1, 2, and 3, OR
     - "16" on Section E, Item 1, OR
     - "8" on Section E, Items 2 and 3, OR
     - "36" on Section H, Items 1, 2, and 3
     - Or, if they receive the following minimum scores in two or more areas:
     - "3" on Section B, Items 1, 2, and 3
     - "8" on Section E, Item 1
     - "4" on Section E, Item 2 and 3
     - "18" on Section H, Items 1, 2, and 3
   - How to Receive Reimbursement: Submit the adapted MDS on all Medical Assistance clients directly to DXC. All MDS forms must be signed by an R.N., dated, and totaled for each section. Claims submitted for clients meeting the acuity standard should be billed at the correct amount

with a modifier. Note: Some claims may have two modifiers if the client meets the high acuity determination and the service is provided evenings, nights, weekends or holidays.

h. Dental services: on the basis of a negotiated fee schedule.

i. Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by the optometrist, whichever the individual may select.

(1) Outpatient and Specialty Drugs Dispensing Fee and Ingredient Cost

a. Payment for covered outpatient and specialty drugs dispensed to beneficiaries residing in the community includes the drug's ingredient cost plus an $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

b. Payment for outpatient and specialty drugs dispensed to beneficiaries residing in an institutional long-term care facility will include the drug ingredient cost plus a $7.90 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

c. The drug ingredient cost reimbursement shall be the lowest of:
   i. The National Average Drug Acquisition Cost (NADAC); or
   ii. Wholesale Acquisition Cost (WAC) + 0%; or
   iii. The Federal Upper Limit (FUL); or
   iv. The State Maximum Allowed Cost (SMAC); or
   v. First Data Bank Consolidated Price 2 (SWD) – 19%; or
   vi. Submitted price; or
   vii. The providers' usual and customary (U & C) charge to the public, as identified by the claim charge.

(2) Clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence.

a. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee included.

b. The drug ingredient cost reimbursement shall be the lowest of:
   i. The National Average Drug Acquisition Cost (NADAC); or
   ii. Wholesale Acquisition Cost (WAC) + 0%; or
   iii. The State Maximum Allowed Cost (SMAC); or
   iv. First Data Bank Consolidated Price 2 (SWD) – 19%; or
   v. Submitted price; or
   vi. The providers' usual and customary (U & C) charge to the public, as identified by the claim charge.

(3) 340B Covered Entities

340B covered entities that fill Medicaid beneficiaries' prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed at the actual acquisition cost for the drug plus a $8.96 professional dispensing fee. Drugs acquired by a covered entity under the 340B program and dispensed by the covered entity's contract pharmacy are not reimbursed.

Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus $8.96 professional dispensing fee.

(4) Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost (as defined in defined in §447.502) for the drug plus a $8.96 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

(5) Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (as defined in defined in §447.502).

(6) All Indian Health Service, tribal, and urban Indian pharmacies are paid at the encounter rate (also known as the "OMB Rate" or "IHS All-Inclusive Rate").

(7) Investigational drugs are not a covered service.

(8) Dentures: on the basis of a negotiated fee schedule.

(9) Surgical and prosthetic devices: all payments are made for covered

*The output for First Data Bank's Consolidated Price 2 (SWD) is based on the application of the following criteria:
1. If Suggested Wholesale Price (SWP) is available, SWP will be output.
2. If SWP is not available, WAC will be output.
3. If neither SWP nor WAC are available, Direct Price will be output.

Items on the basis of the current prevailing rate at which the item is generally available to the public in the State of Rhode Island.

(4) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rate was set as of April 1993 for frames and March 2009 for lenses and is effective for services provided on or after those dates. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf

m. Nurse midwife services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of nurse mid-wife services. The agency's fee schedule rate was set as of 2000 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf

n. Hospice Services: Reimbursement for Hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day.

Effective July 1, 2019, with the exception of payment for physician services, base rates for levels of hospice care are as follows:

- Routine Home Care Days 1-60: $239.05 per day
- Routine Home Care Days 60+: $187.75 per day
- Continuous Home Care: $50.40 per hour
- Inpatient Respite Care: $225.22 per day
- General Inpatient Care: $920.81 per day
- Service Intensity Add-On (SIA)-Clinical Social Worker: $50.44 per hour
- Service Intensity Add-On (SIA)-Registered Nurse: $53.68 per hour

Effective October 1, 2019, the hospice rates will be for each individual level of hospice care to pay the greater of either:

1. The hospice rate listed above; or
2. The current Medicaid minimum hospice rate published by CMS (effective 10/1/19)

The following methodology will be used to calculate the subsequent hospice rates for the individual levels of care:

- Each July 1, the rates effective October 1st of the previous calendar year will be trended by the May release of the New England Consumer Price Index card, as determined by the United States Department of Labor for medical care.

- Each October 1, the fee schedule rates will be updated for each individual level of hospice care to pay the greater of either:
    1. The state's current calendar year's July 1st hospice rate; or
    2. The current Medicaid minimum hospice rate published by CMS

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers. The current rates will be published at http://www.eohhs.ri.gov/ProvidersPartners/FeeSchedule.aspx.

Effective July 1, 2019, the rate for Hospice providers room and board expenses in a skilled nursing facility shall be ninety-five percent (95%) of the state plan skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid members enrolled in the hospice during the same period, beginning with services rendered October 1 or each year and ending September 30 of the next year.

p. Home and community-based services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of home and community-based services. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/HomeandCommunityBasedServices.aspx

q. Rehabilitative services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of February 2012 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf.

r. Case management services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of case management services. The agency's fee schedule rate was set under the specific program that case management operates in a specific instance and is effective for services provided on or after those dates. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf.

Diagnostic Services

Lead Investigations

Payment Methodology

The payment basis for this service is a one-time investigation amount to determine the source of lead.

Payment is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). The child must be diagnosed as having an elevated blood lead level. Medicaid reimbursement is not available for any testing of substances (water, paint, etc.) which are sent to a laboratory for analysis.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

13D. Rehabilitative Services (cont.)

Clinician's Services

Definition:

Clinician's Services refer to services rendered to eligible recipients with mental or emotional disorders. Services include, but are not limited to, assessment and evaluation, psychological and neuropsychological assessment and evaluation, individual, and group therapy, medication treatment and review. With the exception of medication treatment and review, clinician's services do not include those services that are part of another community mental health service, such as psychiatric rehabilitation program components, crisis intervention services, or services defined as case management under the case management option of the state plan.

Provider Qualifications:

Services are reimbursable in accordance with a treatment plan approved by a physician or other licensed practitioner of the healing arts. A licensed practitioner of the healing arts is defined as a:

1. Physician
2. Licensed Psychologist
3. Registered Nurse licensed to practice under Rhode Island State Law
4. Licensed Independent Clinical Social Worker (LICSW).
5. Licensed Marriage and Family Therapist
6. Licensed Mental Health Counselor

TN No. 08-011 Approval Date 5/27/2009 Effective Date 9/01/2008
Supersedes
TN No. 00-006

Rehabilitative Services (cont.)

Adult Behavioral Health Services

Community Psychiatric Supportive Treatment (CPST)

Payment Methodology

Service time billed must be for direct, face-to-face contact with a client or collateral on an individual basis. Travel time, telephone time, and time spent writing case notes are not billable.

The basis of payment is a 15-minute unit of service per qualified provider. Payments are made to or on behalf of the qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Psychiatric Rehabilitation Services (PRS)

Payment Methodology

A PRS visit must last a minimum of 60 minutes in order to bill. After meeting the minimum requirement, time spent face-to-face with the client during any single continuous contact over and above the initial 60 minutes may be billed in15-minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Crisis Intervention Services

Payment Methodology

Billable crisis intervention services can include an emergency intake on a new client if that client is in crisis, but cannot include the routine intakes that occur when this service is also used as the central intake point for the provider. Crisis intervention services delivered by telephone are not reimbursable. The need for extensive telephone work has been calculated into the overall fee structure. A crisis worker can bill for only one eligible client at any given time.

The basis of payment is a 30-minute unit of service per qualified provider. Payments are made to or on behalf of the qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Residential Services

Payment Methodology

The MHPRR rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program. This would include basic social skills development and support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized activities in their community.

Payment is on a per diem basis.

Payment does not include room and board.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;

b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Substance Abuse Assessment Services

Payment Methodology

Payment is based on a fee schedule of 15 minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Outpatient Counseling Services

Payment Methodology

Payment is based on a fee schedule of 15-minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Detoxification Services

Payment Methodology

Payment is based on a per diem basis.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;

b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Substance Abuse Residential Services

Payment Methodology

The rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program.

Payment is based on a per diem basis.

Payment does not include room and board.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;

b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Day/Evening Treatment

Payment Methodology

Payment is based on a per diem basis.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;

b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Children's Behavioral Health Services

Child and Adolescent Intensive Treatment Services (CAITS)

Payment Methodology

Reimbursement is based on the units of service approved as part of an authorized Treatment Plan. CAITS requires prior authorization (PA) from DHS. The maximum number of units is fixed for each procedure code and should be delivered within 16 weeks or less. Although the authorization process approves a set number of units per procedure, how services are delivered is directly determined by the treatment needs of each child. This authorization process allows providers the flexibility to utilize units in accordance with need.

The maximum hours and unit of payment for each reimbursable service are described below. The maximum hour limits doe not apply to EPSDT.

Individual/Family Therapy
Payment is in 15-minute units per qualified provider
The maximum number of units is limited to 40 hours

Family Training and Support Worker Services
Payment is in 15-minute units per qualified provider
The maximum number of units is limited to 18 hours

Treatment Plan Development
Payment is on the basis of a fee schedule. Payment is limited to the development of one treatment plan.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of August 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Mental Health Emergency Service Interventions;
Comprehensive Emergency Services
Enhanced Early Start
Day Treatment Program
Payment Methodology
Services are reimbursed based on a fee schedule.
Fees are determined on a per diem basis.
The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:
a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
b. cost information by practitioner type and by type of service actually delivered within the service unit.
Future rate updates will be based on information obtained from the providers.
Rate Increases
The State does not increase rates based on a set inflation factor on a pre-determined basis.
Date of Effective Rates:
The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Residential Treatment Programs
Payment Methodology
The rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program.
Payment is on a per diem basis.
Payment does not include room and board.
The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:
a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
b. cost information by practitioner type and by type of service actually delivered within the service unit.
Future rate updates will be based on information obtained from the providers.
Rate Increases
The State does not increase rates based on a set inflation factor on a pre-determined basis.
Date of Effective Rates:
The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Rehabilitative Services (cont.)

Adult Day Health Services

Payment Methodology:
Services are reimbursed based upon acuity. The RI Medicaid Agency pays Adult Day Health (ADH) providers for Adult Day Health only if 1) the ADH services are medically necessary as outlined in the Provider Certification Standards, 2) the participant meets the clinical criteria for RI Medicaid Payment and 3) the ADH provider has obtained clinical authorization for RI Medicaid payment in accordance with the requirements set forth in the Provider Certification Standards. The RI Medicaid Agency pays one of two different payment rates for ADH services depending on the level of care and services provided to a participant by an ADH provider, as defined herein. Payment rates do not include room and board.

Basic Level of Services

- The RI Medicaid Agency pays the Basic Rate if the clinical determination is Preventive and the ADH furnishes Basic level of services. Basic level of services include the provision of the coordination of health and social services, including the availability of nursing services, health oversight and monitoring, skilled services, personal care, and care coordination as identified in the person centered care plan, aimed at stabilizing or improving self -care as well as preventing or postponing or reducing the need for institutional placement.

Enhanced Level of Services

- The RI Medicaid Agency pays the Enhanced Rate if the clinical determination is Preventive and the ADH furnishes Enhanced level of services. Enhanced level of services include the provision of:

  a. Daily assistance*, on site in the center, with at least two (2) Activities of Daily Living (ADL) described herein, or;
  b. Daily assistance*, on site in the center, with at least one skilled service, by a Registered Professional Nurse (RN) or a Licensed Practical Nurse (LPN), or;
  c. Daily assistance*, on site in the center, with at least one (1) ADL described herein which requires a two-person assist to complete the ADL, or;
  d. Daily assistance*, on site in the center, with at least 3 ADLs as described herein when supervision and cueing are needed to complete the ADLs identified, or;
  e. An individual who has been diagnosed with Alzheimer's disease or other related dementia, or a mental health diagnosis, as determined by a physician, and requires regular staff interventions due to safety concerns related to elopement risk or other behaviors and inappropriate behaviors that adversely impact themselves or others. Such behaviors and interventions must be documented in the participant's care plan and in the required progress notes.

*Daily assistance= every day of attendance

Payment Rates

Code	Per Full Day (Five (5) or more hrs including transportation to and from provider)	Description
S5102-U1	$ 78.00	Enhanced Level of Services
S5102	$ 58.00	Basic Level of Services

Code	Per Half Day (Three (3) or more hrs including transportation to and from provider)	Description
S5012-U1	$ 39.00	Enhanced Level of Services
S5102	$ 29.00	Basic Level of Services

Rehabilitative Services (cont.)

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
b. Cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases
The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:
The agency rates were set as of October 1, 2018 and are effective for services on or after that date.

Traumatic Brain Injury Services

Payment Methodology
The rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program.
Payment is on a per diem basis.
Payment does not include room and board.
The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases
The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:
The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

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Rehabilitative Services (cont.)

Centers of Excellence for Opioid Treatment

Payment Methodology:
Effective November 1, 2016, the RI Medicaid Agency pays Centers of Excellence for Opioid Treatment (COE) providers for services only if 1) the participant has been diagnosed with opioid use disorder and is appropriate for MAT and 2) the COE provider has obtained certification as a COE from RI BHDDH in accordance with the requirements set forth in the Provider Certification Standards. The RI Medicaid Agency will pay COE providers a one-time payment per enrollee for induction activities at the time of initial enrollment/assessment and thereafter, a per diem payment until date of discharge to community, but no longer than six (6) months, unless the provider was granted approval from BHDDH for extension of enhanced COE services. The RI Medicaid Agency pays one of two different induction payment rates for COE services depending on the capacity of providers, as defined herein. Providers are not able to bill the induction fee and a per diem rate on the same day.

COE Induction Fee
COEs will be certified at two levels to ensure timely access to MAT services. Level 1 providers are those that have the ability to meet the requirement of admitting all individuals within twenty-four (24) hours of referral. Level 2 providers are those that have the ability to meet the requirement to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday. Level 1 providers will receive an enhanced rate for induction to support the requirement of having physician availability seven (7) days per week. The Induction payment is structured to capture the costs for the initial assessment process (complete biopsychosocial assessments, physical examination, observed medication induction, and initial individualized treatment planning).

Per Diem COE Rate
Post induction, the RI Medicaid Agency will pay providers a per diem bundled rate until date of discharge to community, but no longer than six (6) months. The per diem bundled rate accounts for all COE services (continued individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis). COE rates do not include the cost of the medications, nor does it include the continued outpatient clinical, case management and peer support services that COEs will provide to patients who have successfully discharged to the community. The COE provider will need to bill FFS for these services.

Payment Rates

Payment Type	Payment Amount	Limitations
Level 1 Induction Fee	$600.00 per member	Limited to one induction fee per enrollee per six (6) month enrollment. Providers must seek prior authorization if more than one induction must occur in the six (6) month period, (if patient is discharged and then relapses).
Level 2 Induction Fee	$400.00 per member	Limited to one induction fee per enrollee per six (6) month enrollment. Providers must seek prior authorization if more than one induction must occur in the six (6) month period, (if patient is discharged and then relapses).
Per Diem Bundled Rate	$17.86 per member per day	Limited to six (6) months duration, unless the provider was granted approval from BHDDH for extension of enhanced COE services

s. Federally Qualified Health Centers

X The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

X The payment methodology for FQHCs and RHCs will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:
1. Is agreed to by the State and the center or clinic, and
2. Results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

Until the PPS is calculated, the State shall continue to reimburse the core and ambulatory services provided in a FQHC/RHC under its current methodology: one hundred percent (100%) of reasonable cost as defined by the Medicare cost reimbursement principles as set forth in 42CR Part 413.

t. Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: according to negotiated fee schedule.

u. Homemaker Services: Standard fee per fifteen minutes of service.

x. Personal Emergency Response System: according to negotiated fee schedule.

y. Transportation Services: In the plan, state-developed fee schedule rates are the same for both governmental and private providers of emergency transportation. All rates are published at http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims/FeeSchedule.aspx

STATE OF RHODE ISLAND

y. Preventive Services:

- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Smoking Cessation. The agency's fee schedule rate was set as of October 1, 2010 and is effective for services provided on or after that date. All rates are published on the DHS website www.dhs.ri.gov.
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Nutritional Services. The agency's fee schedule rate was set as of January 1, 2002 and is effective for services provided on or after that date. All rates are published the DHS website www.dhs.ri.gov.

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z. Physical Therapy, Occupational Therapy, and Speech Therapy

- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physical Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Occupational Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Speech Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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State Plan under Title XIX of the Social Security Act

State: Rhode Island

Increased Primary Care Service Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. Rhode Island has only one Medicare GPCI.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code. The adjustments are based on rates calculated by Deloitte. The state will not adjust the fee schedule for changes in Medicare throughout the year.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99315, 99316, 99339, 99340, 99344, 99345, 99350, 99359, 99363, 99364, 99366, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489, 99495, 99496

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460, 90461, 99224, 99225, 99226 (all codes added effective 1/1/2011)

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate as implemented by the state in CYs 2013 and 2014.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

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☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____$8.16_____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____
_____
_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/MedicaidPrimaryCareFeeIncrease/tabid/1009/Default.aspx

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/MedicaidPrimaryCareFeeIncrease/tabid/1009/Default.aspx

CONDITIONS UNDER WHICH PAYMENT IS MADE TO RESERVE A BED

The Rhode Island Medical Assistance Program will recognize payment for reserve bed days in Intermediate Care Facilities for the Mentally Retarded as provided for in Section 42 CFR 447.40. Reserved bed days will be considered for the temporary absence of an ICF-MR resident in the following instances.

1. Hospitalization.
2. An overnight visit with family as a part of an individual treatment plan.
3. Participation in resident camp and other overnight recreational activities as a part of an individual treatment plan.

This policy is being implemented in order to facilitate compliance with the provisions of Section 42 CFR 442.414 which require ICF-MR's to encourage frequent and informal home visits by ICF-MR residents and have rules which will make it easy to arrange home visits. Additionally, this provision is being made in order to minimize the physical and emotional stress when residents are required to leave Intermediate Care Facilities for the Mentally Retarded for the purpose of obtaining acute hospital care and to allow residents to participate in overnight family home visits and other recreational activities related to the individual treatment plan.

All temporary absences except for hospitalizations from the Intermediate Care Facility for the Mentally Retarded must be documented in the individual treatment plan. The individual treatment plan must provide for the temporary absence from the facility and the reason for the absence. In cases of hospi-

talization, in order for the facility to assign reserve bed days, the attending physician must document in the medical record that the resident should be able to return to the ICF-MR upon discharge from the hospital.

The Medical Assistance Program will only recognize reserve bed days for each individual that are reasonable in number. For example, it is anticipated that resident camp experiences will be for a period of one or two weeks and that visits with family will be normally for weekends and holidays. The number of reserve bed days assigned should be at a level as to reflect the fact that the primary place of residence is the Intermediate Care Facility for the Mentally Retarded and not the family residence.

On a monthly basis, the facility must submit a copy of the attached Reserved Bed Days Reporting Form to the Department of Social and Rehabilitative Services, NIC Unit, 600 New London Avenue, Cranston, Rhode Island 02920.

Every reserved bed day properly assigned by an Intermediate Care Facility for the Mentally Retarded and recognized for payment by the Rhode Island Medical Assistance Program will count as an occupied bed day for the purposes of reimbursement for Intermediate Care Facility services.

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RESERVED BED DAYS REPORTING FORM

Facility _____ Month _____ Year _____

Resident Name	Medical Assistance Case Number	Dates of Reserved Bed Days	Number of Reserved Bed Days	Reason for Absence From Facility